**PATIENT REGISTRATION FORM**

DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ZIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TELEPHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_SEX\_\_\_\_\_\_\_\_

SOCIAL SECURITY NO.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYED YES\_\_\_\_ NO\_\_\_\_ OCCUPATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME PHONE\_\_\_\_\_\_\_\_\_\_\_ CELL PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-MAIL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONTACT PREFERENCE \_\_\_ CELL \_\_\_ EMAIL\_\_\_ WORK \_\_\_ HOME

INSURANCE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POLICY #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GROUP#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURED'S NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_

RELATION TO INSURED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT REFERRED BY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT'S PCP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PCP PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHARMACY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE NO.\_\_\_\_\_\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH QUESTIONS:**

Is your general health good? YES\_\_\_\_ NO\_\_\_\_

Are you under a physician's care now? YES\_\_\_\_ NO\_\_\_\_

Have you ever had heart trouble, rheumatic fever,

diabetes or infectious hepatitis? YES\_\_\_\_ NO\_\_\_\_

Have you ever had trouble with bleeding after surgery? YES\_\_\_\_ NO\_\_\_\_

Have you ever had an unusual reaction to any drug

or local anesthetic? YES\_\_\_\_ NO\_\_\_\_

Is there any other information about your health which

should be known? YES\_\_\_\_ NO\_\_\_\_

I directly assign all medical benefits to All-American Allergy Asthma & Immunology Center.

I hereby authorize the doctors to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

**How did you hear about us? You may select more than one if applicable.**

**Physician\_\_\_\_ Other Patients\_\_\_\_ Phonebook\_\_\_\_ Online \_\_\_\_ Evaluation\_\_\_\_ Insurance Provider List\_\_\_\_**